Values, Meanings, Hermeneutics and Mental Health

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40.1 Introduction

Mary (not her real name), the woman whose story is described below, was seen at the Neuropsychiatry Clinic of the Queen Mary Hospital in Hong Kong. This is the only tertiary referral centre for neuropsychiatric disorders serving the whole of the Hong Kong. She had agreed to the referral by her psychiatrist because her involuntary movements were not responding to treatment. Her story is based on that of a real person but her name and other identifying details have been changed to protect confidentiality.

Mary's story illustrates some of the ways in which values (notably cultural in origin) influence the experience, expression, interpretation and treatment of bodily symptoms; and how these in turn interact with the management of mental health issues related to underlying and unaddressed psychosocial and spiritual values. I will first present her story in the form of a medical case history and then offer a brief hermeneutic analysis of her story as a narrative in which there is a complex interplay between values, culture, meanings and mental health. Finally, I will return to Mary's story to show how the medical assessment and hermeneutic understanding together guided the way her problems were managed and the outcomes of her story.

40.2 Mary's Neuropsychiatric History

Mary was a 46 year-old married clerk who had been depressed on and off for a decade and probably with a brief episode of psychotic breakdown. She was referred to the Neuropsychiatry Clinic for assessment of persistent abnormal movements

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apparently arising as side effects of the medication she had been prescribed for her mood disorder with psychotic symptoms.

She had seen two private psychiatrists over a period of about 7 years. The first had prescribed a number of antidepressants and antipsychotics (including risperidone). Over a 5-year period on this regime she had shown no obvious improvement and indeed had developed muscle twitching and tremor. A neurological assessment including various scans revealed no abnormal findings. The neurologist concluded that she had 'tardive dyskinesia' and 'dystonia' affecting the muscles of her face and her right upper limb. These are forms of movement disorder known to occur as side effects particularly of antipsychotic medications such as risperidone. The second private psychiatrist thus stopped Mary's risperidone and switched her to a different antidepressant and an anti-anxiety agent, diazepam. These changes had been made 2 years previously but she had continued to be anxious and depressed and there had been no improvement in her involuntary movements.

In her background, there was no family history of mental illness or movement disorders. Her birth was uneventful and her early milestones were normal. As a child she had been generally well apart from a tendency to falls that she developed around the age of 6. A paediatrician advised that this was due to the fact that her legs were of slightly unequal length. The difference however was only noticeable through measurement and no treatment was indicated. She had no other medical or psychiatric history other than as an adult developing episodes of dizziness, tremor and anxiety after skipping meals in order to finish her work on time. These were compatible with hypoglycaemia (low blood sugar) and she had never had any form of eating disorder.

Her childhood was generally happy apart from an episode of serious sexual assault when she was just 13 years old. What happened was that she was attacked by a stranger on her way home from school who dragged her into a road side bush, pulled her trousers off, and tried to have sex with her. Fortunately, a passer-by realised what was happening and chased the man away. Mary meantime ran home and did not tell anyone what had happened.

Mary was average at school and managed to enrol in a university where she successfully completed a diploma in English. She went on to get work as a clerk and to get married. There were however on-going stresses both at work and in her marriage. As to her work, she had been employed in clerical roles since leaving university but found work very stressful. This was not because of the workload but because of never-ending problems dealing with difficult colleagues.

The stresses in her marriage on the other hand were sexual and psychosocial in nature. She had been married for 17 years by the time she was seen in the Clinic but the marriage had never been consummated. The difficulties seemed to arise from the fact that before they married she had told her then husband-to-be that she had had sex in a previous relationship. She had decided to make this confession because she believed at the time that as they were both practicing Christians she had to be honest with her future husband. The result was that when they attempted sexual intimacy on the first night of their marriage Mary had experienced dyspareunia (pain on intercourse) and her husband had given up because he did not want to hurt her.

After this experience they started to sleep in separate rooms. Mary regretted her confession. She stopped attending church with her husband and they slowly drifted apart. They considered divorce but decided against that because it was against their religion. Mary had suggested they might see a marriage guidance counsellor but her husband had repeatedly rejected this idea. Importantly, Mary had not spoken of her marital difficulties with either her neurologist or psychiatrist because they had not asked her about her sexual history.

She described herself as sentimental and an introvert, not good at dealing with stress and a person who preferred to avoid confrontation at all cost. She enjoyed music, drawing and cinema.

Physical examination in the Neuropsychiatry Clinic revealed physiological tremor of both hands but no involuntary movements suggesting dyskinesia or dystonia. She only had one brief startle like movement during the 2-h assessment and that happened when she was performing Mini Mental State Examination (MMSE). She said that was what she was told as her movement disorder. There was no localising or lateralising sign. She was anxious and depressed. She was not suicidal. Her speech was spontaneous and coherent. Thought form and content was normal. No perceptual disturbance was elicited. She scored 28/30 for MMSE as she was very nervous during this assessment, managing only one out of three items for 3-min recall. She did very well on other items otherwise. Her insight and judgement were good: she was fully aware of her longstanding anxiety and depression but was puzzled and frustrated about her involuntary movements which had been diagnosed as tardive dyskinesia and dystonia secondary to the use of Risperidone.

40.3 Hermeneutic Analysis

The relevance of hermeneutic analysis is that one of the key issues of the patient-psychiatrist interaction is how to address the tension between the subjective and the objective, and between explanation and understanding. The former focuses on cause and effect and is empiricist. The latter is concerned with significance and is meaning-based.

In essence, the patient-psychiatrist interaction involves how to correlate between or bring together the subjective (experience, expression and understanding of symptoms from a first-person perspective) and the objective (observation, organization and explanation of symptoms from the third-person perspective) with the aim to find a formulation that makes sense to both parties leading to a management plan that can achieve remission of symptoms, rehabilitation of functions and recovery of health and well-being.

There are two key challenges. One is that of multiple discourses in psychiatry—biological, psychological, social and spiritual. How does a psychiatrist help patients make sense of the relationship between these different discourses? How can and should a psychiatrist promote dialogues between these different discourses in order that patients can have a whole person discourse rather than a fragmented or incoherent one? The other one is that mental health and ill health are experienced and

expressed by a person within a cultural context. How can we facilitate these different culturally contextualized voices to be heard and understood properly between patients and psychiatrists especially in this day and age of cultural plurality and diversity?

The discipline of psychiatry has not done well with respect to these challenges. There has been an unfortunate swing of psychiatry between "brainlessness" (*neglecting* neurobiology) and "mindlessness" (*over-focusing* on neurosciences) at different phases of her development [1]. There is in addition an ongoing ambivalence or negligence of the relevance of culture religion and spirituality to psychiatry [2, 3].

Schleiermacher's nineteenth-century notion of the "hermeneutic circle" showed us that the process of interpretation is an open if not never-ending pursuit, oscillating between the understanding of the whole and the analysis of the part of whatever we are to study. Dilthey's categories of "explanation" (*Erklären*) and "understanding" (*Verstehen*) indicate that understanding and meaning do not arise automatically from demonstrating correlation or causal relations. Heidegger added a metaphysical dimension to our understanding of hermeneutics turning hermeneutics as epistemology into hermeneutics as ontology, arguing that interpreting and understanding are essential features of being human. After Heidegger, Gadamer pushed the argument further, stating that we all have different backgrounds and presuppositions—"prejudice," which is a fact of life that we all need to acknowledge and use as a starting point to achieve optimal mutual understanding. Gadamer called this process of achieving mutual understanding between individuals with different backgrounds and presuppositions a "fusion of horizons," a term that Ricoeur took up when in dialogue with him [4].

Ricoeur in his book, *The Conflict of Interpretations* [5], proposed a crucial step—that of "explaining in order to understand" or as he put it "to explain more in order to understand better" to address the perpetual dialectic between explanation and understanding. His article "Creativity and Language" in *The Philosophy of Paul Ricoeur* [6] develops this step into the process of dialogue between "ordinary" everyday language ("first discourse") and "scientific" or "specialist" languages ("second discourse") and, which in turn has been further expanded to a "third discourse," proposed but never worked out by Ricoeur himself, to bridge the human and the natural sciences, the subjective and the objective, explanation and understanding [4, 7].

This "third discourse" has been formulated subsequently as a multi-layered discourse that is comprehensible to both patients and psychiatrists, not only symptoms but also behaviour and function, correlates biopsychosocial [8] and spiritual dimensions, not reducing them to any particular or single perspective, to explain but *not* to explain away, to understand and search for meaning and significance, explain more in order to understand better, and thus achieving a *therapeutic hermeneutic circle*. It is in this sense a "whole person discourse" in which patients and psychiatrists *explicitly* and *consciously* using ordinary everyday language and "specialist" languages together to express their experience, in a *correlative* but *non-reductive* way that promotes both explanation and understanding [4].

40.4 Hermeneutic Understanding and the Outcomes of Mary's Illness Experience

With this hermeneutic perspective outlined above, Mary's presenting narrative can be summarized as follows:

I am not happy (ordinary discourse) because I had a severe depression and a psychotic breakdown and developed involuntary movements which are the side effects of the antipsychotic medications prescribed to me (biological/neuroscientific discourse). I had a breakdown because of the stress at work and the fact that my marriage was not getting anywhere (psychosocial). My marriage is not even consummated because I told my husband that I had premarital sex which is against our Christian faith (religious/theological discourse). I kind of understand that he is a very religious and traditional man and would find that as sinful and guilty (cultural and ethical) but I thought his love for me can help him overcome that but apparently has not. Now I have to get support from my friends instead (psychosocial) and I wish one day I could make sense of all these with my faith which says truth, goodness and beauty and faith, hope and love will prevail and that I can still be happy healthy and feeling fulfilled even if all these problems never go away (spiritual/religious/theological).

And the hermeneutic analysis can be as below:

Mary presents with a neurobiological problem and expects a pharmacological solution. The psychiatrist clarifies signs and symptoms and advices her that her original neuropsychiatric problem is more or less gone and the so-called persistent involuntary movement is now to do with something else—hypoglycemia which needs to be addressed via a lifestyle adjustment (don't refrain from eating for too long). That relieves her from her neurobiological focus and allows her to discuss her other longstanding and outstanding issues—stress at work, nonconsummation of marriage and ongoing estrangement with her husband. This facilitates, motivates and empowers her to engage with other discourses—ethical/philosophical (is premarital sex right? Should I have lied?) values/cultural (is this simply Christian values or Chinese morality?) and religious/spiritual/theological (now that damages have been done and cannot be undone, how do I achieve meaning, health, happiness and fulfillment again through my faith?)

The outcome of Mary's assessment in the Neuropsychiatry Clinic reflected in part the findings of the medical assessment and in part the deeper understanding of the values and cultural influences on her narrative provided by the hermeneutic understanding as just outlined. The values and cultural factors involved are described further here.

Thus, drawing on her medical assessment, Mary was advised that the neuropsychiatric assessment had found no ongoing evidence of tardive dyskinesia or dystonia. Indeed, these movement disorders were in remission now after the cessation of the antipsychotic (risperidone). Her persistent tremor and exaggerated startled responses were very likely to be part and parcel of her anxiety and depression. She was receptive to this medical reformulation and agreed to try a higher dose of her antidepressant. Drawing however on hermeneutic understanding, she was also

advised to seek help from a Christian therapist with experience in marital and sexual counselling to address the non-consummation of her marriage and on-going psychosexual, relationship and communication problems with her husband.

With this two-pronged medical-plus-hermeneutic approach Mary's anxiety and depressed mood improved. Drawing on the medical side, she managed to see her so called movement disorder more clearly—in place of persistent tardive dyskinesia or dystonia she understood her tremor as being related to anxiety, and its occasional worsening and associated startle response to be a result of episodic hypoglycaemia due to missing meals. She thus started to take regular small meals to prevent hypoglycaemic attacks and found that helped to minimise her anxiety and depression in general and the episodic startle attacks in particular.

Drawing on the spiritual side of her understanding Mary made contact with one of her Christian friends and started to attend an all-women bible study group. She found the fellowship helped her overcome her social isolation and regain her confidence. She became motivated to re-examine her Christian faith and to address her marital and sexual issues from a religious perspective. Her husband seemed to be pleased that she had started to reconnect with her Christian faith. He began talking to her again and on one occasion put his arm around her shoulder to express his care and encouragement, although he withdrew immediately when Mary tried to reciprocate with intimate gestures. Following this incident and drawing on her newfound confidence, Mary brought up the issue of getting help from a Christian marital and sex therapist again. We do not know how this is going to work out yet. But at least her husband said he would consider the idea rather than as he had in the past rejecting it out of hand.

40.5 Hermeneutics Values and Culture

The hermeneutic analysis above suggests a complex interplay between values (her own and those of other people), culture, meanings and mental health.

First, The relationship between behaviour, function and symptoms. Her neurologist interpreted Mary's symptoms as tardive dyskinesia and dystonia and that diagnosis stayed with her despite the change of the nature of her physical signs. She continued to use the same diagnostic labels to describe her own experience and perception. This seems to have been the case for her previous psychiatrists too. One way to understand this is that the diagnostic label given by an expert neurologist has an impact on the capacity of both Mary and her psychiatrists to perceive otherwise. Valuing expert opinions over one's own appears to have influenced the way she interpreted her symptoms which in turn determined how she behaved as a patient and functioned as a wife and at work.

Second, the role of multiple discourses—biological, psychological, social and cultural/religious/spiritual. For Mary, the biological discourse—that she had movement disorders and a sexual dysfunction—played a dominant role in her own personal narrative. The dominance of this discourse had steered her away from her psychosocial and spiritual discourses: yet these were more relevant to her ongoing

stresses and associated psychosexual issues both at a personal and marital level. The reformulation of her highly focused biological discourse into a broader and comprehensive multi-layered correlative and non-reductive one freed her up to review her psychosocial and religious discourses resulting in a re-invigoration in her self-esteem, religious life and marital relationship.

Third, the influence of each of these particular discourses on one's meaning and values system. The particular juxtaposition of different types of discourse in a person reflects one's educational, professional, ethnic, cultural, religious and spiritual backgrounds. The capacity to assemble a relevant multi-layered correlative and non-reductive personal narrative that does not impoverish one's lived experience is not straightforward. In the case of Mary, her interaction with her neurologist, her psychiatrists, her husband and her Christian friends had both positive and negative influences on her capacity and readiness in sorting out how different values systems were affecting her.

Fourth, the increasing relevance of these values as our society is becoming more multi-cultural. The Hong Kong into which Mary was born is predominantly Chinese. The influence of Chinese culture on her roles as an individual, as a wife and as an employee at work is significant. There is an expectation for her as a woman to be submissive and passive and this clearly influenced the way she behaved as a wife, as an employee and as a patient. The value placed on politeness and modesty made her unforthcoming about her sexual and marital issues. The value of social acceptance made her focus on her bodily symptoms rather than her mental health problems (these being still heavily stigmatized) [9]. The cultural influences are further evident in that Mary was brought up in Hong Kong while it was still under British rule. This gave her access to and preference for Western Medicine rather than Traditional Chinese Medicine. The professional and expert status of medical doctors is highly respected, and this further exaggerated the power imbalance in the doctor-patient relationship towards the authoritarian medical side of the dyad. The westernized culture also allowed exposure to the Christian faith that had a significant influence not only on Mary but also her husband, on their sexuality, marriage and relationship. The perceived guilt and sense of sinfulness associated with premarital sex affected Mary's emotional life and that of her husband that it led to non-consummation of their marriage.

Fifth, hermeneutics facilitates values-based practice and improves clinical outcomes. Values-based practice (VBP) is a skills-based approach to working more effectively with complex and conflicting values related to diagnosis and treatment that are not only affected by moral values of patients or ethical and professional codes of psychiatrists but also personal preferences, desires, wishes and expectations of both. VBP is not straightforward and involves beginning with an awareness of values, clarity of where values are in the reasoning process and improving knowledge of values, followed by using communication to resolve value conflicts, starting with patients' values, resolving conflicts in values by balancing different values rather than by a pre-prescribed rule and making decisions in partnership with patients, and finally achieving the right outcome by good process and by applying the above principles of VBP and not by an outcome based on previously laid down

regulations or rules [10]. This whole process requires from both patients and psychiatrists starting from the beginning to the end non-stop attention to presuppositions, assumptions, beliefs, habits, preferences, biases and prejudices, constant dialogue, clarification and negotiation as well as repeated reflections, revision, reformulation and decision. All these tasks are facilitated by hermeneutics which acknowledges the plurality and diversity of narratives, polysemy in words, surplus of meaning and conflict of interpretations of any discourse. The notion of hermeneutics that "to explain more in order to understand better" provides an approach that emphasizes the importance of ongoing dialogue between evidence-based practice and values-based practice and promotes the partnership between patients and psychiatrists in achieving personalization of care and improving clinical outcome.

40.6 Conclusions

The experience and expression of mental ill health involve a complex interplay of values and culture that goes beyond the familiar biopsychosocial formulation. Psychiatry has been limited by her tendency to swing between the extremes of "brainlessness" (neglecting neurobiology) and "mindlessness" (over-focusing on neurosciences) as well as her ongoing ambivalence and negligence of culture religion and spirituality. This results in sub-optimal explanation and understanding of the clinical needs of patients. Hermeneutic commentary that analyses clinical history as a multi-layered personal narrative and formulates intervention and management in a correlative and non-reductive manner provides a whole person and personalized approach that facilitates values-based practice (VBP) and improves clinical outcome.

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40.7 Guide to Further Source

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